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The Provider Perspective on Behavioral Health Care for Transgender and Gender Nonconforming Individuals in the Central Great Plains: A Qualitative Study of Approaches and Needs

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Abstract

Purpose: Transgender and gender nonconforming (TGNC) individuals interact with mental health care systems at high rates and experience substantial barriers to care. Rural TGNC individuals face additional disparities in accessing appropriate mental health services. Little research has focused on the mental healthcare providers who work with TGNC individuals in underserved areas. The current study sought to describe the mental health care services delivered by providers perceived as affirming by TGNC community members in the Central Great Plains.

Methods: We conducted qualitative interviews with 10 providers to understand how providers seek cultural competency and conceptualize and work with their TGNC clients given the barriers to care.

Results: Providers held diverse theoretical orientations and described challenges to working with TGNC clients including the impact of stigma and marginalization and financial and structural barriers to care. Emphasis was placed on individualizing care, helping clients manage stigma and build resiliency, connecting clients to resources (when available) and support systems, and navigating the intersections of physical health care and mental health care such as writing letters for medical transition. Providers largely educated themselves on TGNC topics and had previous experience working with marginalized populations.

Conclusions: Overall, the providers' approaches to working with TGNC clients mapped on to models of cultural competency but few providers described their work in the context of an evidence-based model. Implications for increasing the quality and availability of mental health care services for TGNC individuals in underserved areas are discussed.

Keywords: transgender; gender minority; mental health providers; affirmative mental healthcare; rural or underserved; cultural competency; stigma and marginalization

Public Policy Statement: Affirming mental healthcare providers working with transgender and gender nonconforming (TGNC) clients in underserved areas strive towards cultural competency, but lack of resources and structural barriers to care prohibit wide dissemination of affirming evidence-based care. This study highlights the need for increased research and evidence-informed policy regarding the delivery of mental health services to TGNC individuals in underserved areas.

The Provider Perspective on Behavioral Health Care for Transgender and Gender Nonconforming Individuals in the Central Great Plains: A Qualitative Study of Approaches and Needs

After publications appeared in the 1970's and 1980's that demonstrated that psychotherapy outcomes were poorer for certain cultural groups such as racial and ethnic minorities, researchers and clinicians explored how to rectify the disparate outcomes. These efforts included reducing barriers to utilization (e.g., Snowden & Cheung, 1990), adapting approaches (e.g., Boyd, 1982), and increasing the multicultural competence of providers (e.g., Bernal & Padilla, 1982). There are encouraging data that such efforts improve outcomes (Griner & Smith, 2006). Another aspect of this movement has been the efforts of professional associations to publish guidelines for various groups such as the American Psychological Association's guidelines for general multicultural practice (2003; 2017), sexual minorities (American Psychological Association, 2012), and, most recently, transgender and gender non-conforming people (TGNC; American Psychological Association, 2015).

The history of TGNC people and psychotherapy is a complex one given that the mental health community has historically considered non-cisgender identities as disordered (Green, McGowan, Levi, Wallbank, & Whittle, 2011; Shulman et al., 2017). Even now the World Professional Association of Transgender Health's (WPATH) Standards of Care (Coleman et al., 2012) that guide access to medical transition procedures such as hormones and surgeries include mental health providers as gatekeepers by offering recommendations for steps TGNC people take before getting referral letters for medical transition services. Unfortunately, the historic requirement to see mental health care has not meant that such care is available in a competent or affirming manner and negative experiences in psychotherapy for TGNC people are well-

documented (e.g., Mizock & Lundquiest, 2016; Shipherd, Green, & Abramowitz, 2010). A discussion of the gatekeeper role is beyond the scope of this paper (see XXX Author's paper under review), but greater information on best practices for mental health providers who work with TGNC people is needed to improve access to the best care, especially given the increased visibility of TGNC people in the culture at large.

Transgender and gender nonconforming (TGNC) individuals identify with a gender other than the gender they were assigned at birth. Recent estimates indicate between 700,000 or up to 1% of the U.S. population identify as TGNC across the lifetime (Gates, 2011; Olyslager & Conway, 2007). TGNC people interact with health care systems, particularly mental health care systems, at high rates – perhaps as high as 75% (James et al., 2016). Several factors contribute to this high utilization rate including systemic requirements of a mental health evaluation or continual therapy for medical transition services and increased prevalence of mental health problems such as depression, anxiety, and suicide risk (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Clements-Noelle, Marx, Guzman, & Katz, 2001; Seelman, 2016), largely due to experiences of stigma and discrimination (Hendriks & Testa, 2012; Meyer, 2003). This qualitative study of Great Central Plains TGNC-affirming mental health care providers aims to elucidate gaps in care for TGNC persons in non-coastal spaces from community-identified affirming providers' perspectives.

Although gender and sexual minority populations as a whole face high rates of mental health problems, subsets of these groups, such as TGNC individuals living in rural areas, meet additional risks. A small literature indicates these disparities include high prevalence of depression, suicide, substance use, and sexual risk taking behavior (Rosenkratz, Black, Abreu, Aleshire, & Fallin-Bennet, 2016). Additionally, compared to their non-rural counterparts, rural

trans women experience higher somatization and rural trans men report higher somatization and depression and lower self-esteem (Horvath, Iantaffi, Swinburne-Romine, & Bockting, 2014). Of particular importance to this study, Su et al. (2016) examined mental health disparities between TGNC people and LGB people in Nebraska, a largely rural and underserved state in the Central Great Plains. More TGNC Nebraskans reported past week depressive symptoms (53.9% versus 33.4%) and lifetime suicide attempts (37.7% versus 15.9%) compared to LGB Nebraskans. Little additional research about TGNC individuals living in the Central Great Plains is available. As such, we will review the more general rural TGNC literature to examine possible differences between more conservative, non-coastal regions such as the Central Great Plains and more progressive, urban centers.

On top of these mental health disparities, intersecting marginalized identities mean rural TGNC individuals confront substantial barriers to care. Despite the additional disparities TGNC populations face, most research regarding barriers to care for rural populations has combined sexual and gender minority samples. When trying to access physical and mental health care, LGBT individuals in rural areas report experiencing stigma and discrimination (Rosenkratz et al., 2016), which can lead to avoiding care (Willging, Salvador, & Kano, 2006a). There is a dearth of providers in rural locales and those who do provide services to LGBT patients are perceived as lacking education and knowledge specific to treating LGBT clients (Rosenkratz et al., 2016). Socioeconomic concerns, such as lack of access to transportation and cost of services, also make accessing healthcare for rural TGNC even more prohibitive (Koch & Knutson, 2016; Rosenkratz et al., 2016). One study that examined LGB and TGNC individuals separately found rural TGNC individuals face difficulties beyond rural LGB individuals when accessing primary care (Whitehead, Shaver, & Stephenson, 2016). Rural TGNC people were more likely than rural LGB

people to travel over an hour to a primary care office and more highly valued the provider having LGBT-specific knowledge, indicative in the 10% of the sample who traveled to a LGBT specific clinic in an urban area. Additionally, TGNC participants reported more stigma than cisgender participants, including more anticipated and enacted stigma which were related to lower self-reported health scores. These additional disparities and barriers to care highlight the need for more research that separates sexual and gender minorities.

A common barrier across geographic location is finding affirming clinicians, and little is known about clinicians' experiences working with TGNC clients (Koch & Knutson, 2016; Radix, Lelutiy-Winberger, & Gamarel, 2014). A few studies have examined health care providers' experiences working with TGNC clients. Physical and mental health care providers have been asked about their interactions and competency with TGNC clients (Beagan et al., 2013; Carabez et al., 2015; Whitman & Han, 2017). These studies demonstrate the difficulties TGNC patients report, such as a lack of knowledge and training and misunderstanding of trans terminology.

Most studies that include mental health care providers' experiences working with TGNC clients are actually focused on experiences with LGBT clients. When therapists were asked to describe helpful and unhelpful situations with LGBT clients, therapists felt best about working with clients when they were knowledgeable and affirming of LGBT issues but some therapists reported negative experiences like reacting poorly to a client's disclosure or being unprepared to work with complex identities (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008). In a national sample of 384 psychologists working in Veteran Administration (VA) settings, 84% reported strongly agreeing or agreeing that they could competently treat LGB veterans while only 36.2% reported feeling competent to treat TGNC veterans (Johnson & Federman, 2014). Additionally,

VA psychologists in more progressive areas had more positive attitudes towards TGNC veterans, such as believing they should have access to hormone therapy, than psychologists in more conservative areas (many of which are rural), further highlighting the association of geographic location and TGNC individuals' ability to locate affirmative care (Holt, Hope, Mocarski, & Woodruff, 2018).

These issues demand consideration of how providers can become culturally competent to work with TGNC clients. Sue, Arredondo, and McDavis (1992) offer a model of cultural competency with 3 components: awareness, knowledge, and skill. Applied to TGNC populations, this suggests that therapists must be aware of their own biases and attitudes toward gender minority individuals, have knowledge about TGNC communities and issues, such as common experiences across both social and medical transition, and have the skills to appropriately and sensitively work with TGNC clients, such as assessing gender dysphoria and understanding how a client's gender history and identity may impact mental health. Goldberg (2006) suggested a tiered model of competencies that moves from a basic level of providing affirming and welcoming services toward intermediate and advanced competencies, such as incorporating TGNC stressors into case conceptualizations. Goldberg's model highlights a move from *cultural* competence to *clinical* competence. This sentiment has been echoed by our team's Local Community Board, a group of TGNC individuals who advise and guide research, as they advocate for clinicians with "good brains," not just a "good heart."

Some community competency trainings have been used to increase knowledge related to TGNC health with the hopes of improving patient-provider relationships and level of care. These trainings have generated significant improvement in knowledge, but with small effect sizes (Hanssmann, Morrison, & Russian, 2008; Hanssmann, Morrison, Russian, Shiu-Thornton, &

Bowen, 2010). Out of these trainings come recommendations to educate providers about barriers to care, to give providers tools to interact with a diverse group of individuals, and to provide information about community resources, and medical and legal policies impacting TGNC populations (Hanssmann et al., 2008). Overall, the field has been slow to establish measures of cultural competency for working with TGNC clients and competency to work with these populations requires more than basic training in generalist programs (Perosa, Perosa, & Queener, 2008). One way to learn how providers successfully work towards cultural competency is speaking with providers identified by the community as culturally sensitive and responsive.

Few studies have examined the experiences of mental health providers who work with LGBT clients regularly. Willging, Salvador, and Kano (2006b) interviewed 20 rural mental healthcare providers in New Mexico who were locally known for working with LGBT clients. The majority of these providers demonstrated a "therapeutic neutrality" by stating there were no differences working with LGBT populations and non-LGBT populations. The providers reported being accepting of LGBT people but did not have much education on LGBT issues as only one provider had specific LGBT training. Willging and colleagues reasoned that the therapeutic neutrality could be harmful to clients as providers discounted an important aspect of their clients' identity.

In a more recent study, shuster (2016) interviewed 23 health care providers about how they negotiate transgender health guidelines and standards, such as the WPATH's Standards of Care (Coleman et al., 2012). shuster selected participants based on their considerable work in TGNC healthcare. Providers used two distinct strategies when dealing with uncertainty regarding medical transition services: work flexibly with the guidelines or follow them closely. Providers who closely followed the guidelines often maintained gatekeeping roles and expected their

TGNC patients to be completely certain about the medical transition services they wanted. These providers were still empathetic about the possibility that closely following the guidelines can be prohibitive for people trying to access services. The other strategy, to flexibly apply the guidelines, meant providers worked to balance power dynamics with their clients. Mental health providers discussed trying to avoid gate keeping, such as writing letters that say "I support this person's decision" instead of offering a recommendation and only providing the necessary and sufficient information to get their clients access to services.

Several guidelines and clinical recommendations offer ideals for the type of care TGNC individuals should receive (American Psychological Association, 2015; Chang & Singh, 2016; Coleman et al., 2012). For example, the American Psychological Association (2015) offered broad guidelines such as psychologists' need to understand that gender is non-binary and may differ from gender assigned at birth and recognition that stigma and prejudice impact the well-being of TGNC people. The WPATH Standards of Care (Coleman et al., 2012) largely focus on medical concerns for TGNC people and the mental health section primarily discusses the role of mental health clinicians in helping TGNC people socially and medically transition. Although useful, these guidelines are often broad, focused on medical transition services, not widely disseminated, or encourage practices that can be stigmatizing to TGNC clients, such as gatekeeping roles (Hope, Mocarski, Bautistia, & Holt, 2016; Whitman & Han, 2017). Additionally, the published guidelines often do not include specifics about delivery of mental health services to rural or underserved TGNC populations (Walinksy & Whitcomb, 2010), leaving providers and patients in these areas to fend for themselves.

Clinicians who have been identified as affirming by TGNC communities can help elucidate the care available to further marginalized individuals in resource-limited areas, such as

the Central Great Plains. The purpose of this study is to describe the mental health care services delivered by providers to TGNC clients in an underserved area. Using qualitative interviews analyzed via an open and axial coding approach with constant comparison, we sought to understand the qualities of the providers that TGNC individuals describe as affirming, how these providers seek competency, what topics are commonly discussed with TGNC clients, and how providers conceptualize and work with their TGNC clients given the barriers to care in an underserved area.

Method

Participants and Procedures

Mental health care providers were recruited to participate through recommendations from TGNC community members in the Central Great Plains, the Trans Collaborations Local Community Board, and the authors' professional networks. For example, the Local Community Board provided TGNC community members with recruitment flyers to give mental health care providers that were recognized for their affirmative work with TGNC clients. Potential participants were given recruitment flyers and instructed to contact the research team if they were interested in participating. Participants were required to be over 19 years of age (age of majority in Nebraska) and provide mental health services to TGNC individuals. All procedures were approved by the University of Nebraska-Lincoln Institutional Review Board.

Participants completed a semi-structured interview with the first author and the second author attended three interviews. Interviews were conducted in a quiet location of the participants' choosing, often their office, or online over a HIPAA compliant teleconferencing system. Two participants completed interviews online. The interviews occurred between March

2016 and February 2017 and were between 28 minutes and 1 hour and 2 minutes in length. The interviews were audio recorded and then transcribed and de-identified. Participants were compensated $50 for their time.

Ten mental health care providers working in the Central Great Plains region participated in the semi-structured interviews and completed a demographic form. When asked about their gender identities, 7 participants identified as women, including one woman with a trans history, and 3 participants identified as men. Eight participants reported their age. The ages of participants ranged from 44 years to 76 years with an average of 56.4 years. Five participants identified as heterosexual, 4 identified as a sexual minority (gay, lesbian, queer, and pansexual) and 1 participant did not report their sexual orientation. Two participants described themselves as living in a rural area and 8 reported living in an urban area. All 10 participants identified as European American. Nine participants reported their employment status, all as being employed full-time. Nine participants described their relationship status. Six participants reported being married or in a marriage-like relationship, 2 reported being divorced, and 1 reported being single and never married.

Provider information detailed in interviews. Providers detailed additional demographic and career trajectory information during the interviews. The mental health care providers who were interviewed had diverse academic backgrounds and theoretical orientations. Nine providers were Master's level clinicians and one provider had a PhD in Clinical Psychology. The Master's level clinicians had degrees in guidance and counseling, social work, counseling, mental health counseling, and counseling psychology. Providers ranged in the number of years they had worked as a clinician from 2 years to 34 years, with 8 participants practicing for over 10 years. When asked to describe their theoretical orientations and approaches to therapy, providers

identified drawing from Adlerian psychology, Jungian psychology, object relations, cognitive behavioral therapy, dialectical behavior therapy, transpersonal philosophy, narrative approaches, and psychodynamic theories.

Our sample of providers had varying years of experience working with TGNC clients (2 years to 10+ years), but similar paths to doing this work. Several providers had been involved with community organizations focusing on LGBT issues and gained exposure throughout the community as being active and supportive. Some providers' first TGNC client was by happenstance and then a perceived specialization developed as word of mouth spread that they provided TGNC-affirmative care. A connection with TGNC communities and referrals via those communities connected several providers with potential clients.

Additionally, many providers had a history of working with other marginalized groups before establishing a caseload of TGNC clients. Providers had experience working with LGB populations, survivors of sex trafficking, individuals with serious mental illness, and people in the justice system, including incarcerated offenders. One provider described that previous experience with clients who face societal stigma has informed her current therapeutic approach with TGNC clients by emphasizing therapy as a safe space for clients to explore their lives, no matter where they have been in the past. Providers described attending workshops and conferences, consulting with other therapists and professionals, and doing their own reading on TGNC topics.

Providers stated they work with TGNC clients of all ages, though the interview questions were focused on work with adult TGNC clients. Clients sought mental health services for both medical and social transition-related services, such as coming out to family, mental health concerns, or obtaining a letter to begin hormone therapy. For example, providers reported that

emotional issues, such as having depression, anxiety, or suicidal thoughts, may motivate a TGNC individual to seek care. Additional problems that led TGNC clients to seek mental health care were family conflicts, substance use, and eating disorders. Providers described that mental health concerns often intersected and compounded with TGNC-specific issues, including stigma and lack of social support, which can complicate the delivery of mental health services.

Measures

Demographics. Participants completed a demographics measure that included questions about age, gender identity, sexual orientation, race/ethnicity, relationship status, employment status, and urban/rural status. Gender identity was asked with an open-ended question and participants were able to specify their identity for sexual orientation and race/ethnicity if it was not in the provided list.

Interview guide. A list of thematic hubs served as a guide for the interviews, however the interviews were often driven by the interviewee and relevant topics based on their own lives and professional experiences. Each of the hubs was addressed in the course of the interviews, but the order was dictated by each individual conversation flow. Furthermore the interviewer was allowed to use additional questions to further explore topics that arose. The interview guide is available in Appendix A.

The thematic hubs were Life History, Services Provided, Stigma and Resilience, Community Resources, and Challenges to Health/Psychological Treatment[1]. Providers discussed their professional backgrounds and theoretical orientations, how they became connected with

[1] Participants also provided feedback on the language, content, and utility of a progress monitoring measure for use with TGNC clients that is not included in the scope of this article.

TGNC clients and communities, and how they approach working with TGNC clients. The Stigma and Resilience hub concerned how stigma and discrimination impact TGNC clients, ways to help clients manage these issues, and strengths and resiliency of their TGNC clients. Providers also described the types of resources (or lack thereof) available to TGNC communities, how they help clients access those resources, and challenges and barriers for TGNC individuals trying to access affirmative physical and psychological health care.

Analysis

The fourth author analyzed the interviews according to Weiss' approach of coding, sorting, local integration, and inclusive integration (1994), a method used previously in health research (e.g. Sison et al., 2013). During the coding stage, the fourth author read through the interview transcripts and generated thematic categories that emerged from the data. Categories served as a level of abstraction and were created if multiple examples across participants appeared in the data. In the sorting stage, the researcher created a copy of the coded transcripts and sorted the data into the categories generated during step one. It is typical for a single section of an interview transcript to have multiple codes. A copy of each transcript section was placed into all relevant categories. Each category thus has the coded transcript and a reference to the research participant (i.e., Provider 1), so that the original data source could be easily located. In the third stage of analysis, local integration, the researcher examined each thematic category to identify consistency and variation within the theme. Any negative cases were identified and labeled in this stage. Local integration is used to ensure each theme has a solid base of support from the coded data. Finally, the researcher engaged in inclusive integration by looking across themes and interpreting the data in a more holistic approach. Axial codes emerged at this stage to create an overarching framework. The first author utilized this analysis, but also provided level

of scrutiny to the coding in drafting this manuscript. She utilized the axial-level codes as a guide with attention paid to open codes and the transcriptions themselves to draft the manuscript, all filtered through her lens as a mental health provider with experience working with TGNC clients.

Results

Two major axial themes emerged from the data: Topics of Discussion in Therapy and Challenges and Considerations for Working with TGNC Clients. The first theme is presented in Table 1 to demonstrate what topics frequently arose in therapy with TGNC clients. We provide more detail regarding the codes and analysis of the second theme, Challenges and Considerations for Working with TGNC Clients.

Table 1. Topics of Discussion in Therapy

General topics	Examples of topic
Social transition steps	Dress and appearance, informal name change, legal name change, disclosure, navigating gendered facilities
Transition-related medical services	Hormone therapy, gender affirmation surgery, referral letters
Barriers to care	Insurance, financial issues
Stigma/Resiliency	Belonging to an oppressed group
Impact of additional identities on gender journey	Racial/ethnic minorities, non-binary individuals, low socioeconomic status
Emotions	Scared, depressed, anxious, ashamed, traumatized

Connecting to community	Community network provides information, joining a group, becoming an advocate
Others' reactions to disclosure	Reactions by family, friends, co-workers, and significant others

Challenges and Considerations for Working with TGNC Clients

Practicing self-reflection. The providers demonstrated self-reflection when discussing their work with TGNC clients. Some providers expressed a comfort with asking questions or recognizing their own limitations. These limitations may be addressed by seeking out research or resources or directly asking a client, as one provider described:

> "They use a term … I am like, "Ok, I don't know what that one means so please educate me, please, please," and they just laugh. And, "Oh this is what it means," … I am not embarrassed if I don't know, I am happy to ask so that is what keeps me maybe more fresh is that I … never present as I am the expert. "I am not the expert here, I will ask some of the right questions but you [the client] are the expert on you." (Participant 5)

Providers also demonstrated self-reflection by considering how their therapy space could be interpreted by TGNC clients. One provider specified that she would not display religious material in her office so as to not stigmatize TGNC clients and another described changing the gender and sexual orientation options on her intake sheet to be more inclusive. A provider reported a client told her "I know I am in the right place" upon seeing her inclusive intake form.

Advocacy. Provider's work with TGNC clients includes a dimension of advocacy. For example, one provider noted juggling multiple roles: "I think you have to wear a lot of hats. Like I am helping clients navigate how to change their name and what to expect with hormones

and who the best surgeons are and so I am wearing medical, legal, mental health [hats] a lot of times." (Provider 4) Additionally, providers demonstrated broad knowledge of locale-specific climate for TGNC people, such as specific school districts' policies regarding TGNC students' access to restroom and locker room facilities and being aware of places in a small town where it is safe for TGNC people to dine out and to work.

Managing stigma. The presence of stigma and discrimination in the lives of TGNC clients was pervasive throughout our interviews. Providers described their TGNC clients as having several negative emotions, such as feeling scared, depressed, anxious, ashamed, and suicidal. Although these emotions can happen independent of a TGNC identity, providers' discussion of these negative emotions often implicated societal stigma due to gender identity. Providers identified that TGNC clients experience fear in healthcare settings, such as being scared to trust a provider, depression that is worsened by a lack of support system, and anxiety from concealing their gender identity. One provider elaborated "I have yet to meet a transgender person, a gender nonconforming person who hasn't experienced some trauma just based on the fact that they are transgender." (Participant 10) Rarely were mental health issues that TGNC clients experience not attributed to stigma.

Stigma was also discussed in several contexts, including healthcare systems, family systems, online spaces, workplaces, religion and faith, schools, cultural messages, and within the legal system. These different layers complicated health status and how providers worked with TGNC clients. One provider even worried her TGNC clients may be too embarrassed to fully disclose the extent of their discriminatory experiences with her. Providers noted how these several levels of stigma and discrimination may impact their clients. For example, one provider described how experiences of stigma may differ based on age, geographic location, and religion:

> "Younger folks have had more exposure and experience with all kinds of LGBT stuff and so they know more and I think they can be less fearful, but not necessarily. If you are from Podunk, Minnesota and your church is … a hellfire church … [younger folks may have] fear in the physical sense because we all know people get killed and have and continue to be so I think … all these things [fears] are rational." (Provider 3)

This example indicates providers are aware of their clients' intersecting identities and possibility for heightened stigmatizing experiences.

One of the most common ways several providers described buffering against stigma is helping clients develop their relationships and connections to communities. This could require examining the clients' current relationships to see if they are helpful or harmful and replacing support systems, if necessary. The supports could be formal, such as connecting clients to a TGNC support group, or informal, as one provider identified that being in a committed relationship can increase resiliency. Providers highlighted the importance of ensuring TGNC clients' relationships are affirming, as relationships can also be sources of stigma and further complicate mental health issues.

Resiliency. In order to help combat stigma, providers described the importance of TGNC clients' resiliency. Providers see their TGNC clients seeking mental health services as an act of resiliency and strength. Resiliency can be encouraged and built upon in therapy, as detailed by one provider:

> "I really do look for resilience. I look for whatever they are, when I say resilience, are they tenacious? Is this something that they've been consistent insistent and persistent about and they are not going to back down? Those are strengths that we really do

> celebrate. You know the ways that they can celebrate affirmations about themselves, looking for other people to affirm them. And … insolate them with their supports …we will go through and identify what are some of the positive affirmations that you use? What are things that we can change to be more desired coping thoughts to help you through the transition or help you with your supports or families?" (Provider 5)

This process may involve asking clients to describe other times they have persevered or accomplished a difficult task in order to identify their strengths and conditions that facilitate resiliency. Additionally, providers help clients find affirmations they can tell themselves and encourage accessing support from people who can provide affirmation – both related and unrelated to gender.

Individualizing care. Several providers discussed the importance of "meeting clients where they are at" in order to individualize care. This included discovering where a client may be in their gender journey, where they want to go, and, to an extent, allowing the client to lead. Exploring these issues has substantial impacts on the course of therapy, including influencing if a therapist feels comfortable writing a referral letter for medical transition as one provider described: "Everybody is individualized. It really does depend on their maturity level, how long they've identified, you know, what their transition or what their experience has been" (Provider 5). Providers also described meeting clients where they are requires creating a safe space for exploration and may include being comfortable with and helping clients tolerate ambiguity related to gender and dealing with unexpected changes, like shifts in sexuality.

Barriers to accessing care. Providers identified finances and insurance as substantial barriers for their TGNC clients accessing care. One provider posited that fewer clients ask for referrals for surgery due to economic hardships and a dearth of surgeons willing to provide these

services in the region. Insurance companies may ask providers for more detailed progress notes, strict diagnostic requirements in order to cover gender-affirming medical procedures, and arbitrarily decide what services their TGNC clients can access. One provider explained how insurance regulations differed from her professional opinion and created barriers to care:

> "Besides the therapy and the hormones I think … the surgical changes are medical necessity. I think the [insurance companies] aren't on board with that … I got 3 or 4 letters from (insurance company), for instance, after somebody had gone to start their hormones. Then I would get a letter saying … "Let's have your progress notes and your diagnosis on what's going on here." … then towards the end of the year I got some [letters] from (same insurance company), "These are what we are going to allow and these are not." … to me the gender dysphoria indicates a medical necessity to have the body changes, it's not just, "I want plastic surgery to change my nose." (Provider 8)

These barriers to care impact the providers' work by creating more stigma in their clients' lives and limiting access to care.

Another major barrier to care many providers acknowledged is TGNC clients being able to find TGNC-affirmative health care providers. TGNC clients may cycle through several providers until finding a therapist or physician who is competent and a suitable match for the client. Providers expressed discontent with the low number of TGNC-competent physicians and mental health care providers in the region. Emphasis was placed on clients needing *competent* providers, not just TGNC-*friendly* providers. How providers advertise to TGNC clients contributes to the barrier of finding an appropriate therapist. One provider described her experience of advertising on *Psychology Today*:

> "When I look at therapists' profiles online, which I have done, every therapist in the world says that they are experts in working with trans folks with trans issues and LGBT issues and whatever. And that just makes me shiver because I know not all those people know what they are doing so how people know where to go is a big barrier." (Participant 3)

Another provider suggested that the lack of TGNC-competent providers means TGNC clients must meet with multiple therapists before finding a good match.

Intersectionality. Belonging to different identity groups and other demographic factors emerged as impactful on TGNC clients' experiences. In particular, being an ethnic minority, an older adult or a minor, overweight, non-binary, or a transwoman may make TGNC experiences more difficult. Several providers acknowledged the additional difficulties of TGNC clients that belong to an additional minority group and provided ways they address these topics in therapy. For example, one provider highlighted the importance of being "aware of all of the identities in the room" and representation:

> "When we talk about race, I think most of the research that we have, most of the support groups are very white washed…there is really a lack of diversity where people feel welcome and … we know that so much of what's important is that you see yourself reflected back to you in the world and I think that is something that I really work with a lot of clients, is like coming up with their own narrative because there aren't any out there. So if you don't see yourself reflected back, do you exist? And if you don't exist how do you move towards that?" (Provider 4)

Additional examples of challenges for clients based on intersecting identities were loss of male privilege for transwomen, homelessness and financial hardship for low socioeconomic individuals, and absence of non-binary media representations.

Intersections of health care and mental health care. Perhaps more so than with cisgender clients, mental health care providers working with TGNC clients frequently intersect with physical health care, largely due to referral letter requirements for medical transition services. All providers in our sample discussed letter requirements for hormone therapy and gender-affirmation surgeries. Providers usually stated that they take an individualized approach to deciding if they will write a letter for each client who asks. An individualized approach means most providers do not have set requirements that clients must meet before they can receive a letter. They described several clients who sought mental health services just for a letter and were able to obtain a letter quickly, often in just a couple sessions, with no additional requirements imposed by the therapist. In these cases, the letter requirement was usually viewed as gate-keeping. However, many providers reported they see the reasoning for a letter requirement for individuals with more severe mental illness that can be affected by hormones. Many providers described writing letters not as rubber stamping their TGNC clients as ready to begin medical transition, but as a way to provide physicians additional information and explain a client's individual case:

> "I am having mixed feelings about that [a letter requirement] and … I think we have to treat everybody as an individual and I think informed consent can really work with some people and I think as much as it's a gate-keepery … sometimes people have very lived histories and that some of those things may impact hormones. You know, I think about people I work with who are on the autistic spectrum or people with bipolar disorder and I

> know that surgeries or certain hormones can affect that, so that would be something I would want people [medical providers] to have information … so I think some of that is helpful in the sense that we can kind of disseminate that information just so people can feel really prepared for what they may experience." (Provider 4)

Providers overwhelmingly had mixed feelings about the necessity of letters, as described above. There was consensus that the practice is gate-keeping, but no clear path to remove therapists from the process exists at the present time.

In sum, providers identified by the TGNC community were from diverse professional backgrounds and theoretical orientations and had substantial experience with marginalized communities, suggesting those skills translated to work with TGNC clients. Beyond this previous experience, providers also engaged in self-education on TGNC issues and connected with communities to seek cultural competency. The providers saw TGNC clients for both general mental health problems, such as depression and anxiety, and gender-related issues common of one's gender journey, such as coming out or helping clients access medical transition services. Yet regardless of the presenting problem, providers described incorporating the influence of gender and stigma into understanding all mental health issues. Providers identified the importance of social support either from family, chosen family, or a larger community as a way to help clients manage stigma. Several barriers to care complicated how providers reach and work with TGNC clients such as economic insecurity, geographic distance, and limited community resources, often described as being magnified because of the Great Plains location. These barriers caused providers to operate as advocates and case managers to help their clients navigate barriers and connect with available resources, going beyond the scope of a traditional therapeutic alliance.

Discussion

This study documented practices and experiences of mental health care providers working with TGNC clients in the Central Great Plains. The providers were identified by TGNC community members as providing TGNC-affirmative services in underserved locales. Compared to previous studies with therapists who regularly work with TGNC or LGBT clients, our sample of providers generally used a more individualized approach. For example, they did not display "therapeutic neutrality" and appeared more likely to make adaptations for TGNC clients than Willging et al. found (2006b). As noted above, shuster (2016) identified two groups of therapists: one group implemented standards of care quite flexibly while another used a more rigid approach. Our providers mostly described an individualized approach to writing referral letters that seems to fall in between the flexible approach and rigid approach that shuster described. Providers did not have strict requirements for providing a TGNC client with a referral letter, but some providers expressed hesitancy that could translate to additional gate-keeping (creating additional requirements or lengthening the time it takes TGNC individuals to access gender-affirming medical care). Although there is some variability in how the standards of care are applied, it appears that many of the providers were not explicitly following the standards of care nor were they utilizing an informed consent model.

Providers' conceptualizations of and work with TGNC clients largely mapped on to Sue et al.'s (1992) model of cultural competency. Providers demonstrated awareness of their own beliefs by asking questions of their clients and recognizing their own limitations (such as referring clients who are seeking a letter for gender-affirmation surgery – a tactic that could be viewed as non-affirming but is not disqualifying given the few providers available in the Central Great Plains). Knowledge was discussed as providers mentioned seeking out additional training

by reading TGNC literature and attending TGNC conferences. Prior experience with other marginalized groups helped inform their knowledge about the impact of stigma and discrimination on TGNC clients. Many providers were trained before TGNC topics were included in therapist training, meaning most providers acquired knowledge of TGNC topics on their own volition. The providers also demonstrated skills necessary to work with TGNC clients such as connecting people to community resources and enhancing clients' resiliency, competencies identified by the American Counseling Association (Burnes et al., 2010). Beyond the original tripartite model of cultural competency, providers also described advocacy work, which has been integrated into models of cultural competency (Sue, 2001). Providers' adherence to the components of cultural competency suggests awareness of beliefs, knowledge, skills, and advocacy may be important to TGNC people as they select therapists. Additionally, several providers seemed to be moving beyond cultural competency towards clinical competency (Goldberg, 2006). This meant providers exceeded simple TGNC-affirming practices, such as using inclusive intake forms, to recognizing interactions between the individual client and their specific social context.

In addition to striving for culturally-responsive services, we approach our own clinical work with TGNC individuals from an evidence-based model (American Psychological Association, 2006). Few providers in the sample described their work in the context of the entire APA evidence-based care model. Much of the providers' responses focused on client characteristics, including recognizing the impact of stigma on their TGNC clients, and clinical judgment, such as applying their previous experience with marginalized groups to their current clinical practice. There was little discussion of research evidence or adapting empirically supported interventions or skills for TGNC individuals. For example, many providers stated their

clients had depression, but they did not identify specific evidence-based interventions they would use with TGNC clients to treat their depression, such as behavioral activation or interpersonal therapy, or how such treatments might need to be adapted, despite the interviewers asking explicit questions about treatment adaptation. Overall it appears that most of the therapists considered client characteristics and relied on clinical judgment, but rarely reported using research evidence to guide their clinical practice, in line with findings that clinical experience informs treatment decisions over research findings (Stewart & Chambless, 2007). TGNC clients in the Central Great Plains can seek culturally responsive and TGNC-affirmative therapists, but may struggle to find evidence-based care that is affirming.

Implications

These conversations with mental health care providers who TGNC people in Central Great Plains identify as TGNC-affirming have several implications. First, there are few providers available in this region who specialize in TGNC issues. Several TGNC community members suggested we interview the same providers, indicating providers are well-known within the community. However, this popularity of a few providers means they may have extensive waitlists or be centered in a couple large cities, not accessible to everyone who needs care. It also increases the potential for dual relationships as several individuals in a social circle may be referred to the same therapist. More TGNC-affirming and clinically competent providers are needed to meet the demand of this unserved area and reduce potential ethical problems. Second, more research and guidance is needed regarding letter referrals for medical transition services. Providers had mixed opinions but expressed being uncomfortable with the gate-keeping role perpetuated by letter writing requirements of the standards of care. There is not a consistent letter-writing process used by therapists in the Central Great Plains. TGNC clients still need

access to mental health services and deserve scientifically validated consent procedures to ensure they have the best mental health and medical outcomes for transition-related services. Third, the providers were offering both transition-related services as well as general mental health care. More research is needed to establish both types of evidence-based mental health services for TGNC populations (Hope et al., 2016) and dissemination is required to reach affirming providers

Limitations

This study has a few limitations that should be noted. First, there was no racial diversity in our sample and limited urban/rural diversity, as eight providers described themselves as working in urban areas. Future research should seek a more diverse sample. However, this sample also may be representative of the demographics of TGNC-affirmative providers in the Central Great Plains, which speaks to a larger issue of needing to encourage racial and ethnic diversity in the mental health profession (Steward, Lee, Hogstrom, & Williams, 2017) and providing TGNC training for providers in rural areas (Koch & Knutson, 2016). Another limitation, which is typical of qualitative research, is the limited generalizability of these results to wider populations (Atieno, 2009). It is unknown if the mental health services described by our providers are representative of the type of care in other underserved areas. However, a strength of our sample is that the providers were recommended by TGNC community members and perceived as doing affirmative work, therefore providing some insight about the level of affirming mental health services available in a resource-limited and underserved area. Yet this approach also leads to a limitation that providers could have been recruited for the study if one TGNC client views them as affirming, but this does not preclude the possibility that other TGNC individuals may have had negative experiences with the provider. This possibility is heightened as some providers described tactics that do not demonstrate full clinical competency to work

with TGNC individuals, such as referring clients to another provider for surgical letters. Future research should extend this work to additional geographic regions and employ objective measures of clinical and cultural competency to establish what TGNC-affirmative services are available in traditionally resource-limited areas.

Conclusions

TGNC individuals living in underserved areas, such as the Central Great Plains, face several health disparities and barriers to care. Some providers deemed affirmative by TGNC communities and that strive towards cultural competency are available to alleviate some of need for mental health services. These providers recognize how stigma impacts their TGNC clients experience and are familiar with both mental health needs related to medical transition services and general mental health concerns. Although some affirming care appears to be available, the "good heart" described earlier, we should still aspire towards culturally-responsive evidence based care for these high disparities communities.

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Appendix

Interview Guide

1. Life History
    a. First of all, can you tell me a little bit about yourself?
        i. How long have you lived in _____?
        ii. Can you tell me about your professional background?
        iii. Can you talk about how you became involved with the trans community?
        iv. About how many trans clients have you worked with?
    b. What word(s) do you use to describe your gender? Please tell me about how that fits for you.
2. Services provided
    a. Please share with us what services you provide to the trans community
    b. Please share about your approach when working with trans clients
    c. Are there certain topics/concerns that you believe are important for most trans clients? Certain topics/concerns that come up infrequently?
    d. Sometimes trans individuals seek support for the transition and sometimes they are looking for treatment for anxiety/depression/etc.
        i. Please describe how you see these as separated or related issues
        ii. What do you believe is needed for transition care?
        iii. What do you believe is needed to adapt other treatments to the trans community?
3. Stigma and Resilience
    a. Please discuss how you see stigma and discrimination impacting your trans clients

        i. How do you help them manage these issues?
        ii. Does it vary across settings, stage of transition, etc?
    b. Please discuss what strengths and resilience you see in your trans clients and how you use it in your services?
4. Community Resources
    a. Please describe the resources your clients use in the community and how you help your clients access those resources
5. Challenges to Health/Psychological Treatment
    a. What are challenges to accessing health care for your clients?
    b. What are challenges to accessing psychological care in the community?
6. Measure walk
    a. One thing lacking in psychological services are any sort of trans-friendly questionnaires that can help a trans client and therapist keep track of how well the client is doing in an objective way. Would you look at the questionnaire we have drafted and let us know what you think about the topics and whether the language used in the questionnaire is appropriate and trans-affirming?